

WELCOME

TO



ALLIANCE

SPORTS MEDICINE

ABOUT YOU

Today's Date: _____ / _____ / _____ **E-Mail:** _____

Patient's Name: _____ Preferred Name: _____

Last First MI

Male Female Status: Single Married Divorced Separated Widowed

Birthdate: _____ / _____ / _____ Age: _____ SSN: _____

Mailing Address: _____ Home Phone: _____

_____ Cell Phone: _____

City State Zip Work Phone _____

How did you hear about us: Please Circle

Referral / Website / Google / Yelp / Facebook / Instagram / Other _____

Referred by: _____

Employer: _____ Occupation: _____

Spouse's Name: _____

Do you have children? Yes No How Many? _____

INSURANCE INFORMATION

Insurance Company: _____

Billing Address: _____

Phone # for Provider to call: _____

ID #: _____ Group # _____

Insured's Name: _____ Insured's Employer: _____

Relation: _____

REASON FOR VISIT

The reason for this visit is a result of (Please Circle): work, sports, auto, trauma or chronic

(Explain what happened): _____

Please describe the pain & its location: _____

When did the condition begin? _____ / _____ / _____

Is this condition getting worse? Yes No Constant Comes and Goes

Is this condition interfering with your (Please Circle): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

Have you ever been treated by a Chiropractor before? Yes No

If so, whom? _____ Phone # _____

IN THE EVENT OF AN EMERGENCY

Who should we contact? _____
Relation: _____
Home Phone #: _____ Work #: _____
Who is your Medical Doctor? _____
Phone #: _____



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HEALTH HISTORY

Are you taking any of the following medications?

Nerve pills Pain Killers (including aspirin) Muscle Relaxers Stimulants
 Blood Thinners Tranquilizers Insulin Other (s)

Do you have or ever had any of the following diseases or conditions?

Y	N	Heart Attack/Stroke	Y	N	Heart Surg./Pacemaker	Y	N	Heart Murmur
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse	Y	N	Artificial Valves
Y	N	Alcohol/Drug Abuse	Y	N	Venereal Disease	Y	N	Hepatitis
Y	N	HIV +/-Aids	Y	N	Shingles	Y	N	Cancer
Y	N	Frequent Neck Pain	Y	N	Emphysema/Glaucoma	Y	N	Anemia
Y	N	High/Low Blood Pressure	Y	N	Psychiatric Problems	Y	N	Rheumatic Fever
Y	N	Severe/ Frequent Headaches	Y	N	Kidney Problems	Y	N	Ulcer/Colitis
Y	N	Fainting/Seizures/Epilepsy	Y	N	Sinus Problems	Y	N	Asthma
Y	N	Diabetes/Tuberculosis	Y	N	Difficulty Breathing	Y	N	Chemotherapy
Y	N	Lower Back Problems	Y	N	Artificial Bones/ Joints	Y	N	Arthritis

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to:

List previous surgeries/treatments with dates:

List any past serious accidents with dates:

Family Health History:

Are you on a special diet: Yes No/ Since: _____ / _____ / _____

Do you smoke? No Yes How much? _____ How long? _____

Are you wearing? Heel Lifts Sole Lifts Inner Soles Arch Supports

What is the age of your mattress? _____ Is it comfortable? Yes No

For Women: Are you taking Birth Control? Yes No

Are you Pregnant? No Yes / How long? _____ Nursing? Yes No

ACCOUNT INFO

Person ultimately responsible for account

Name: _____ Relation: _____

Billing Address: _____ SSN: _____ DOB: _____

_____ I hereby authorize assignment of directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered by this office).

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date: _____ / _____ / _____

LIFESTYLE

Do you take Supplements or Vitamins? Yes No

If so what kind: (please circle) Multi Energy Anti Inflammatory Joint Care
 Immune Building Bone Care Other _____

Do you exercise regularly? Yes No If so what type of exercise? _____

Do you have allergies? Yes No If so for how many years? _____

Are you interested in weight loss? Yes No

Current Height _____ ft _____ in

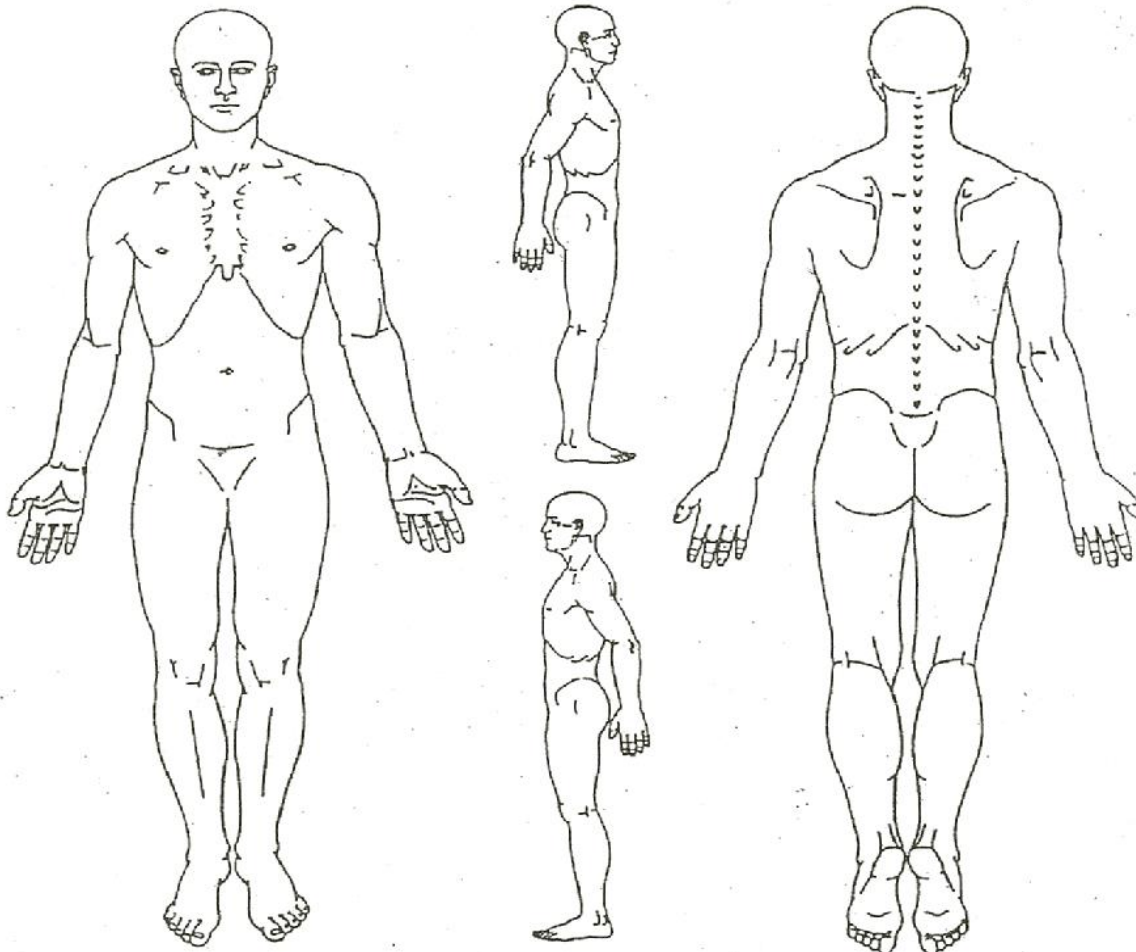
Current Weight _____ lbs

PAIN CHART

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description >>>	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol >>>	NNNN	PPPP	BBBB	AAAA	SSSS





ATHLETE INTAKE FORM

Patient's Name _____

SPORTS

Affiliation: (ex. Alta Tennis) _____

Circle all that apply:

Golf Tennis Football Soccer Cheerleading Running Swimming Biking Weight-Training MMA Baseball Lacrosse

Other _____

Type of Injury: _____

Have you ever taken the Impact test (for concussion)? _____ If yes, when? _____

If you answered "Yes" to the above, please answer the following:

When was the concussion(s)? _____

Were you diagnosed? _____

How long did your symptoms last? _____

Have you been diagnosed or noticed yourself to have food allergies or sensitivities to food items?

If "Yes", who diagnosed you and what foods are you allergic or sensitive to? _____
